CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00194/1**

TITLE: **Global Commitment to Health Section 1115 Demonstration**

AWARDEE: **Vermont Agency of Human Services (AHS)**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Vermont Agency of Human Services (AHS, state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the demonstration, which are enumerated in separate lists. The STCs also detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The amended STCs are effective as of the date of the approval letter through December 31, 2016 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The amended STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. General Reporting Requirements
V. Eligibility
VI. Benefits, and Enrollment
VII. Cost Sharing
VIII. Delivery Systems
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality
XII. Evaluation of the Demonstration
XIII. Use of Demonstration Funds
XIV. Schedule of State Deliverables for the Demonstration Period.

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A. Quarterly Report Content and Format.
Attachment B. Summary of Catamount Health
Attachment C: Premiums and Copayments for Demonstration Expansion Populations

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Global Commitment to Health Section 1115(a) demonstration is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

CMS is extending the Global Commitment to Health demonstration for three years. Effective January 1, 2014, the state will expand coverage to the new adult group under the Affordable Care Act and will terminate the VHAP, CHAP, and ESI programs, as these programs are no longer necessary. The VHAP-Pharmacy and VScript programs are also terminated effective January 1, 2014, because of the availability of pharmacy benefits in the Marketplace. Effective January 1, 2014, Vermont is authorized to provide hospice services to adults concurrently with curative therapy. Also effective January 1, 2014, Designated State Health Program funding is made available to support state programs subsidizing the purchase of insurance in the Marketplace for individuals whose income is above 133 percent of the federal poverty level (FPL) and up to and including 300 percent FPL.

The state's goal in implementing the demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; and
- Containing health care costs.

The state will employ four major elements in achieving the above goals:

1. *Program Flexibility:* Vermont has the flexibility to change benefits for the non-mandatory populations and invest in alternative services and programs designed to achieve the demonstration's objectives;
2. *Managed Care Delivery System:* Under the demonstration the AHS will enter into an agreement with the Department of Vermont Health Access (DVHA), which will operate using a managed care model;
3. *Aggregate Budget Neutrality Cap:* Vermont will be at risk for the caseload and the per capita program expenditures, as well as certain administrative costs for all demonstration populations. Vermont will have to manage this program within a total computable aggregate cap of approximately $13.2 billion over the approved eleven and a quarter year demonstration period. Effective January 1, 2014, the new adult group will not be included in the total computable aggregate cap, but will be subject to a separate per member per month (PMPM) budget neutrality limit; and

4. *Marketplace Subsidy Program:* Effective January 1, 2014, Federal Financial Participation (FFP) will be available for state funds for a Designated State Health Program (DSHP) to provide a premium Marketplace subsidy program to individuals up to and including 300 percent of the FPL who purchase health care coverage in the Marketplace.

The initial Global Commitment to Health demonstration was approved in September of 2005. The demonstration was extended for three years, effective January 1, 2011. The following amendments have been made to the demonstration:

- 2007: a component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost effective employer-sponsored insurance, as determined by the state.

- 2009: the state extended coverage to Vermonters at or below 300 percent of the FPL.

- 2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the state to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state agrees that it must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non-applicable, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy**. The state must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state is not required to submit title XIX state plan amendments for changes to demonstration-eligible populations covered solely through the demonstration. If a population covered through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. Reimbursement of providers will not be limited to reimbursement described in the state plan.

6. **Changes Subject to the Demonstration Amendment Process.** The state must not implement changes to its program that require an amendment without prior approval by CMS, as discussed below. Amendments to the demonstration are not retroactive, and FFP may not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, below.

    The state has the authority to modify the demonstration program design elements in accordance with the parameters specified below. Changes in eligibility or process in determining eligibility requires a demonstration amendment.

    Mandatory State Plan Eligibles. All changes in benefits (whether reductions or additions), including the benefits provided through the approved alternative benefit plan and optional services, for federally mandated populations (including the new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act ("the Act")) must be submitted as an amendment to the state plan.

    Non-Mandatory Eligibles. All proposed changes (whether additions or reductions) in state plan benefits for optional groups must be submitted as an amendment to the state plan; all proposed changes in benefits (whether additions or reductions) for the expansion groups must be submitted as an amendment to the demonstration by the amendment process outlined in STC 7. The state may change the benefit package for the non-mandatory eligible population so long as the state plan benefit changes and/or changes to benefits for the expansion groups result in no more than a 5-percent cumulative increase, or decrease each year of the total Medicaid expenditures for the corresponding demonstration year, and comparison year and as long as the resulting benefit package is consistent with the requirements in STC 19 below.

The following chart indicates the corresponding years:

Demonstration Year (DY)	Comparison Year Expenditures
DY 1 (10/1/2005- 9/30/2006)	2004 Total Global Expenditures (calendar year)
DY 2 (10/1/2006- 9/30/2007)	2005 Total Global Expenditures (calendar year)
DY 3 (10/1/2007- 9/30/2008)	2006 Total Global Expenditures (calendar year)
DY 4 (10/1/2008- 9/30/2009)	2007 Total Global Expenditures (calendar year)
DY 5 (10/1/2009- 9/30/2010)	2008 Total Global Expenditures (calendar year)
DY 6 (10/1/2010- 9/30/2011)	2009 Total Global Expenditures (calendar year)
DY 7 (10/1/2011- 9/30/2012)	2010 Total Global Expenditures (calendar year)
DY 8 (10/1/2012- 9/30/2013)	2011 Total Global Expenditures (calendar year)
DY 9a (10/1/2013-12/31/2013)	2012 Total Global Expenditures (calendar year)
DY 9b (1/1/2014 – 12/31/14)	2012 Total Global Expenditures (calendar year)
DY 10 (1/1/2015- 12/31/2015)	2013 Total Global Expenditures (calendar year)
DY 11 (1/1/2016-12/31/2016)	2014 Total Global Expenditures (calendar year)

The state must offer benefit packages that, at a minimum, include inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, and well-baby, and well-child care, including age appropriate immunizations. However, this does not apply to Populations 7 through 11 as defined in STC 17.

For changes in the non-mandatory populations' benefit package, the state must notify CMS 60 days prior to any expected change in the benefit package. After receipt of the written notification, CMS officials will notify the state if the request needs to be submitted as an amendment to the state plan or an amendment to the demonstration as outlined in STC 7. Should the state fail to notify within the time period or submit an amendment as requested, CMS has the right to withhold or disallow FFP.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. An explanation of the public process used by the state to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

    c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

8. **Frequency of Demonstration Amendments**. Vermont's expectation is that changes to the demonstration will occur at the same time of year each year, based on the outcomes of the legislative session. At the end of the legislative session, the state must submit amendments pursuant to STC 6, and governed by the process outlined in STC 7 of this section. Any approved changes must be reflected in the annual rate-setting process for the upcoming year.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

   a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

   b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

   c. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

   d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the state in writing of the determination and the reasons for suspension or termination of the demonstration, or any withdrawal of an expenditure authority, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish either its rights to challenge the CMS finding that the state materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

12. **Withdrawal of Waiver Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and regulations that implement section 1115(d), as added by section 10201 of the Affordable Care Act.

15. **Compliance with Managed Care Regulations.** The state shall comply with all of the managed care regulations published at 42 CFR section 438 et. seq., except as expressly identified as not applicable in the STCs. The per member, per month fixed amount pursuant to STC 42 must be developed and certified as actuarially sound in accordance with 42 CFR 438.6. DVHA shall continue to serve as the unit designated by AHS (the Single State Agency) responsible for administration of the state Medicaid program and operates as a public managed care model solely to carry out the goals and purposes of the demonstration.

DVHA's role under the demonstration as a public managed care model does not reduce or diminish its authority to operate as the designated Medicaid unit under the approved state plan, including its authority to implement program policies permissible under a state plan and establish provider participation requirements. DVHA shall comply with federal program integrity and audit requirements as if it were a managed care organization for services and populations covered under the demonstration.

16. **Federal Funds Participation (FFP)**. No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Global Commitment to Health demonstration includes four fundamental elements: program flexibility; a health care delivery system administered by the state but modeled after a managed care delivery system; and an aggregate budget neutrality cap. Effective through December 31, 2013, this demonstration also includes premium assistance.

17. **Populations Affected and Eligible under the Demonstration.**
a. Generally: Except for populations described in subparagraph (b) and the additional premium assistance requirements described in subparagraph (c), the following populations listed in the tables below will receive coverage through the Global Commitment to Health demonstration. Coverage for mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in these STCs and the waiver list and expenditure authority for this demonstration. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard on January 1, 2014, will apply to this demonstration.

Changes to the following, outside the parameters as outlined in STC 6, are pursuant to the amendment process as discussed in STCs 7 and 8 under section III, General Program Requirements.

Those non-Medicaid eligible groups described below who are made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this demonstration.

The general categories of populations included under the demonstration are:

Mandatory and Optional State Plan Groups		
Demonstration population number	***Population description***	***Benefits***
Demonstration population 1	Mandatory categorically needy, except for the Affordable Care Act new adult group (included in demonstration population 3) and Medicare Savings Program beneficiaries (included in demonstration populations 7 and 8).	Benefits as described in the title XIX state plan and these STCs.
Demonstration population 2	Optional categorically needy.	Benefits as described in the title XIX state plan and these STCs.
Demonstration population 3	Effective January 1, 2014, the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan.	Benefits as described in approved alternative benefit plan state plan amendment and these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Demonstration population 4	Underinsured children with income that, before January 1, 2013, is between 225 and up to and including 300 percent of the federal poverty level (FPL) or, on or after January 1, 2013, is between 227 and 313 percent of the FPL, who are not otherwise eligible for Medicaid or the Children's Health Insurance Program.	Same benefits as described in the Medicaid state plan and these STCs.
Demonstration population 5	Adults with children with income between 150 and up to and including 185 percent of the FPL. This population shall be categorized as a Vermont Health Access (VHAP) Expansion population. The expenditure authority for this population expires December 31, 2013.	VHAP Limited/VHAP*

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Demonstration population 6	Childless Adults with income up to and including 150 percent of the FPL. This population shall be categorized as a Vermont Health Access (VHAP) Expansion population. The expenditure authority for this population expires December 31, 2013.	VHAP Limited/VHAP*
Demonstration population 7	Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits. The expenditure authority for non-Medicare individuals in this population expires December 31, 2013.	Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX state plan.
Demonstration population 8	Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise categorically eligible for full benefits. The expenditure authority for non-Medicare individuals in this population expires December 31, 2013.	Maintenance Drugs; MSP beneficiaries also receive benefits as described in the title XIX state plan.
Demonstration population 9	Individuals with persistent mental illness with income up to and including 150 percent of the FPL. The expenditure authority for this population expires December 31, 2013.	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Demonstration population 10	Employer-Sponsored Insurance Premium Assistance: a. Adults with children with incomes between 185 and including 300 percent of the FPL without adjustment (gross income). b. Childless adults and non-custodial parents with income between 150 and including 300 percent of the FPL without adjustment (gross income). c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 5 & 6. The expenditure authority for this population expires December 31, 2013.	Premium assistance to purchase ESI.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Demonstration population 11	Catamount Premium Assistance a. Adults with children with incomes between 185 and including 300 percent of the FPL without adjustment (gross income). b. Childless adults and non-custodial parents with income between 150 and including 300 percent of the FPL without adjustment (gross income). c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for demonstration populations 5 & 6. The expenditure authority for this population expires December 31, 2013.	Premium assistance to purchase Catamount Health.

* Effective through December 31, 2013, VHAP Limited is the interim benefit package offered to enrollees before a primary care physician (PCP) is chosen. After the PCP is chosen, the enrollee is eligible for the full VHAP benefits package, referred to as VHAP PC Plus.

Note: The VHAP, VHAP limited, premium assistance for ESI, premium assistance for Catamount Health, V-script, V-script expanded and VHAP pharmacy programs will expire on December 31, 2013.

b. **Exclusions:** The following persons are excluded from the Global Commitment to Health Program:

i. Choices for Care: Individuals covered under the Vermont section 1115 Choices for Care demonstration not receiving Community Rehabilitation and Treatment (CRT) services are excluded from the Global Commitment to Health section 1115 demonstration. Only those Vermont Choice for Care (CfC) beneficiaries receiving CRT services under Global Commitment or moderate eligible services under CfC overlap with the Global Commitment to Health demonstration.

ii. CHIP: Individuals who are eligible for the Children's Health Insurance Program (CHIP) in Vermont.

c. **Additional premium assistance requirements:** For the demonstration's premium assistance programs effective through December 31, 2013 (demonstration populations 10 and 11), the following requirements apply:

i. To be eligible for premium assistance, adults not otherwise eligible for DVHA programs must have been uninsured for 12 months, subject to the exceptions noted in subparagraph (a) above, or six months if the State elects such shorter period and gives 30 days prior notice to CMS. Refer to current Vermont rules and policies for the definition of "uninsured" and other crowd-out provisions related to premium assistance.

ii. Individuals must meet these requirements unless they lost coverage due to one of the following reasons: loss of employment; death of the principal insurance policyholder; divorce or dissolution of a civil union; domestic violence; no longer qualified as a dependent under the plan of a parent or caretaker relative; no longer qualifying for Consolidated Omnibus Budget Reconciliation Act (COBRA), Vermont Continuing Coverage Program (VIPER), or other state continuation coverage; or a college-sponsored insurance plan became unavailable because the individual graduated, took a leave of absence, or otherwise terminated studies.

iii. VHAP adults with access to cost-effective ESI are also eligible to receive premium assistance.

18. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap.** The state must seek approval to modify program eligibility via the demonstration amendment process, as described in STCs 6, 7, and 8 of section III "General Program Requirements." Regardless of any extension of eligibility, the state will be limited to federal funding reflected in the budget neutrality requirements set forth in these STCs.

If program eligibility is expanded or reduced, the state must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for expansion groups. In the event of any reduction in eligibility for expansion and optional populations, the state may continue eligibility for all individuals already enrolled in the program. If the state establishes a waiting list for eligibility or services, priority will be given to state plan mandatory populations over optional populations, and last priority will be given to expansion populations.

19. **Benefits**.

a. All covered services may be subject to medical review and prior approval by DVHA based on medical appropriateness. A complete listing of covered services and limitations are contained in the Vermont approved title XIX state plan, Vermont statutes, regulations, and policies and procedures. The state has the authority to adjust the benefit package for the non-mandatory eligible populations without amendment per STC 6.

Effective through December 31, 2013, the benefits described in this subparagraph (b) and subparagraph (e) apply to this demonstration. Effective January 1, 2014, the benefits described in subparagraphs (c), (d), and (e) of this STC apply to the demonstration.

b. The following benefits are effective through December 31, 2013:

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Inpatient Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan program rules and policies VHAP: Urgent and emergent admissions only
Outpatient Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
FQHC/RHC including ambulatory services offered by FQHCs	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Laboratory/X-ray Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
EPSDT for Individuals Under 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Family Planning Services and Supplies	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Physician Services and Medical and Surgical Services of a Dentist	X	X	State plan: any limitations on this service is described in the approved Title XIX State plan, program rules and policies
Home Health Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Nurse Midwife Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Pediatric/Family Nurse Practitioner	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife, chiropractor)	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Clinic Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Prescribed Drugs	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Diagnostic, Screening, Preventive, and Rehabilitative Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Private Duty Nursing Services	N/A	N/A	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Eyeglasses and Other Aids to Vision	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies Note: Eyeglasses are not covered. Covered services are limited to other aids to vision.
Dental Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Prosthetic Devices	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Inpatient Hospital/Nursing Facility/ ICF Services for Individuals 65 and Older in IMD	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
ICF/MR Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Inpatient Psychiatric Services for Individuals Under 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Personal Care Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Case Management	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Respiratory Care for Ventilator Dependent Individuals	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
PCCM	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
PACE (covered under VT Choice for Care 1115 Demonstration)	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Hospice	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies (Note: Effective January 1, 2014 additional hospice benefits are authorized as describe in paragraph (c) of this section)
Transportation Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Services Provided in a Religious Non-Medical Health Care Institution	N/A	N/A	
Nursing Facility Services for Individuals Under Age 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies. *covered for persons under 18 years old. 18 and older covered in the Choices for Care 1115 Demonstration.
Emergency Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Critical Access Hospital	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in the Vermont Rules and/or policies

Note: Please note that benefit limitations do not apply to children under age 21- in accordance with EPSDT requirements.

The VHAP adults are eligible for premium assistance to purchase ESI if deemed cost-effective by the State. The benefits offered by the plan must be substantially similar to the benefits offered by the typical benefit plans issued by the four health insurers with the greatest amount of covered individuals in the small group market. To ensure that individuals enrolled in VHAP ESI receive the same benefits as individuals in the VHAP program, the State will provide a wrap for services not covered under the ESI plan.

Premium Assistance Catamount Health Plan Benefit Package (Refer to Attachment B)
Comprehensive benefit as prescribed in Catamount State statute

ESI Premium Assistance (Non-VHAP) Benefit Package
The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.

c. Effective January 1, 2014, the Global Commitment to Health demonstration will provide, at a minimum, the benefits covered under the title XIX state plan to individuals in populations 1, 2, and 4, and benefits for individuals in population 3 shall be specified in an approved Alternative Benefit plan under the state plan. Nursing facility services for adults (over the age of 18) in need of long-term care are covered under Vermont's Choices for Care Section 1115 demonstration; nursing facility services for children and other adults are covered under the Global Commitment to Health demonstration as defined in the state plan, state regulation and policy.

d. **Hospice.** Effective January 1, 2014, the state may provide coverage for hospice services concurrently with palliative and curative services. These concurrent services will be available for adults 21 years of age and older who are in populations 1, 2, and 3 who have been diagnosed with a life-limiting illness that is expected to be terminal, if a physician has certified that the adult is within the last months of life. The number of months of life required for such a certification shall be determined under the state plan.

e. **Special programs.** In addition to the services described in subparagraph (a), the state shall provide the following services, through "special programs" to individuals who would have been eligible under a separate 1915(c) waiver or the state's prior 1115 demonstration.

Special Program Name	Services	Limitations
Traumatic Brain Injury (TBI)	HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.	Any limitation on this service defined by Vermont rules and policies
Mental Illness Under 22	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, and crisis and community supports.	Any limitation on this service defined by Vermont rules and policies
Community Rehabilitation and Treatment	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, and crisis and community supports.	Any limitation on this service defined by Vermont rules and policies
Developmental Services	HCBS waiver services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care	Any limitation on this service defined by Vermont rules and policies

20. Palliative Care Program. The Palliative Care Program is for children under the age of 21 years in demonstration populations 1, 2, 3, and 4 who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood. The program will allow for children to receive palliative and curative services.

a. **Participation.** Demonstration participants will be identified based diagnostic codes found on claims data and referrals from medical professionals.

i. Eligibility will be determined by the nurse care manager and/or DVHA Medical Director, based on the assessment tool and supplemental clinical information (as needed). Continued eligibility will be re-assessed at least annually.

ii. Care planning activities for children enrolled in the palliative care program will meet the requirements specified in federal managed care regulations for enrollees with special health care needs.

b. **Benefits.** In addition to state plan services, children enrolled in the palliative care program may also receive care and services that meet the definition of 'medical assistance' contained in section 1905(a) of the Act if determined to be medically appropriate in the child's care plan

i. **Care coordination.** Development and implementation of a family centered care plan that includes telephonic and home visits by a licensed nurse.

ii. **Respite care.** Short term relief for caretaker relatives from the demanding responsibilities for caring for a sick child.

iii. **Expressive Therapies.** Therapies provided by licensed therapist to provide support to the child to help the child to creatively and kinesthetically express their reaction to their illness. The palliative care program offers 52 hours of expressive therapies per year. Additional, expressive therapy may be authorized if medically appropriate.

iv. **Family Training.** Training to teach family members palliative care principles, medical treatment regimen, use of medical equipment, and how to provide in-home care.

v. **Bereavement Counseling.** Anticipatory counseling and up to 6 months after the child's death for the family by a licensed professional trained in grief counseling. Payment for bereavement counseling services may be provided for on-going counseling to family members after the child's death so long as such services were initiated prior to the child's death.

c. **Cost Sharing.** Cost sharing requirements as described in STC 21 will apply.

V. COST SHARING

21. Premiums and cost sharing

a. Populations 1, 2, and 3.

i. Premiums for populations 1, 2, and 3, must be in compliance with Medicaid requirements that are set forth in statute, regulation and policy. Premiums may be charged for this population in accordance with the approved state plan.

ii. Cost sharing for populations 1, 2, and 3, must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447(b) applies to the demonstration.

b. **Populations 4 through 11.** Detailed cost-sharing and premium requirements for demonstration Populations 4 through 11 are included in Attachment C. Cost-sharing for demonstration expansion children eligible for Medicaid must not exceed 5 percent of the family's gross income. In addition, the state must not apply co-payment requirements to excluded populations (children under age 21,

pregnant women or individuals in long-term care facilities) or for excluded services/supplies (e.g., family planning).

VI. DELIVERY SYSTEMS

22. Delivery System Overview. Benefits will be furnished by DVHA which will operate on a managed care model and will be responsible for the delivery of all Medicaid covered services. The DVHA must be authorized by state statute and must adhere to federal regulations at 42 CFR part 438 that would be applicable to a managed care entity unless specifically stated otherwise in the STCs.

23. Non-application of 42 CFR 438.806. The interagency agreement between AHS and DVHA is not considered an MCO contract which would otherwise require CMS prior approval to make FFP available to AHS. Further, the per member, per month fixed amount referenced in STC 42 (PMPM Limits) will only be reviewed by CMS for the purpose of monitoring the aggregate spending limit and not for the purpose of determining FFP under the demonstration.

24. Premium Assistance. Effective through December 31, 2013, there are three programs offering premium assistance under this Demonstration; VHAP-ESI, ESI premium assistance (non-VHAP), and Catamount premium assistance. As the Single State Agency for Medicaid, AHS will have authority and responsibility for eligibility determination related to these premium assistance programs. The role filled by AHS will be identical to that of Single State Agencies in other States. The AHS PMPM limits include these eligibility groups. The methodology for providing premium assistance for each of the three programs is described below:

a. **VHAP-ESI.** AHS determines eligibility, processes enrollment and makes the determination that ESI is cost effective. DVHA transfers to the beneficiary an amount of premium assistance that does not exceed the amount that the employer withholds from the employee's wages for the employee premium share of employer-sponsored insurance.

   DVHA provides additional benefits to ensure that the beneficiary receives the full VHAP benefit package in the aggregate.

b. **ESI Premium Assistance**. AHS determines eligibility, processes enrollment, and makes the determination that the ESI is cost effective. DVHA transfers to the beneficiary an amount of premium assistance that does not exceed the amount that the employer withholds from the employee's wages for the employee premium share. There is a wraparound benefit for prevention and management services to treat certain chronic conditions.

c. **Catamount Premium Assistance**. AHS determines eligibility and processes enrollment in Catamount Premium Assistance. The beneficiary pays a premium contribution to AHS and DVHA pays the total premium for the beneficiary to enroll in a private Catamount Health plan. There is no additional wraparound benefit.

25. Catamount Health. Effective through December 31, 2013, the Catamount Health product will be offered by private health plans in the State as dictated by Vermont Statute Title 8, Chapter 107, and section 4084f. Catamount Health.

26. Submission of Interagency Agreement and PMPM Limit Actuarial Certification.

a. AHS shall provide a copy of the interagency agreement between AHS and DVHA to CMS' Boston regional office no less frequently than annually to ensure compliance with these STCs.
b. AHS shall provide the actuarial certification for the PMPM Limit calculation no less frequently than annually to ensure accurate calculation of the aggregate spending limit.

27. Limitation of Freedom of Choice. Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue).

Specifically, demonstration participants enrolled in a special service program such as, but not limited to specialized substance abuse and behavioral health services or a program for home and community-based services may only have access to the providers enrolled under that program, and will not have access to every Medicaid enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the special service program.

28. Contracts and Provider Payments. Payments to providers will be set by DVHA and will not be required to comply with the payment provisions in the approved state plan, or with federal regulations pertaining to the upper payment limits for provider rates. The AHS will be responsible for oversight of DVHA, ensuring compliance with state and federal statutes, regulations, special terms and conditions, waiver, and expenditure authority. AHS shall be responsible for evaluation, interpretation and enforcement of findings issued by the external quality review organization.

Procurement of health care services by AHS (the Single State Agency) through selective contracting or similar processes, and the subsequent final contracts developed to implement selective contracting by the AHS with any provider group, must be subject to CMS regional office approval prior to implementation.

29. Contracting with Federally Qualified Health Centers (FQHCs). The state must maintain its existing agreements with FQHCs and rural health centers. Effective through December 31, 2013, reimbursement for services provided to individuals enrolled in ESI/Premium Assistance programs must be based on requirements established by the Vermont Statute 2006 Health Care Affordability Act and the terms contained in the independent agreements reached between FQHCs/rural health centers and participating carriers.

30. Data Sharing. DVHA as a state agency may share enrollee data with other state agencies if the use or release of such data is for a purpose directly connected with administration of the plan as defined in section 1902(a)(7) of the Act. DVHA is authorized to use or release de-identified data, as defined in federal privacy regulations, to enable participation in statewide program studies. As a purpose directly connected with plan administration, DVHA is permitted to release enrollee-specific information to providers in order to enable the provider to seek payment for services rendered under the plan. Any other release of enrollee-specific information for a purpose not directly connected with plan administration is prohibited. Consent of the enrollee is required whenever release of enrollee information for a purpose directly connected with plan administration is sought by an outside source, except in an emergency. Release under these conditions is defined in federal regulations at 42 CFR sections 431.306(d).

VIII. DESIGNATED STATE HEALTH PROGRAMS

31. State-Funded Marketplace Subsidies Program. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for individuals up to and including 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is up to and including 300 percent of the FPL.

a. Funding Limit. Expenditures for the subsidies are limited on an annual basis as follows (total computable):

	DY 9b	DY 10	DY 11
DSHP - State-Funded Exchange Subsidy Limit	$9,616,669	$10,247,721	$11,055,193

b. Reporting. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 40. This data must, at a minimum, include:
   i. The number of individuals served by the program;
   ii. The size of the subsidies; and
   iii. A comparison of projected costs with actual costs.

c. Budget Neutrality. This subsidy program will be subject to the budget neutrality limit.

32. State-funded Mental Health Community Rehabilitation (CRT) Services. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration payments through a state funded program for CRT services, as defined by Vermont rule and policy, provided to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not Medicaid enrolled. This program will be subject to the budget neutrality limit.

IX. GENERAL REPORTING REQUIREMENTS

33. General Financial Requirements. The state must comply with all general financial reporting requirements under title XIX set forth in section IX "General Financial Requirements".

34. Compliance with Managed Care Reporting Requirements. The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq., except as expressly identified as not applicable in these STCs.

35. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in section X "Monitoring Budget Neutrality".

36. Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services. The State agrees to track and report expenditures for CRT services to participants with severe and persistent mental illness. Expenditures for CRT mental health services will be included under the budget neutrality agreement for the Vermont Global Commitment to Health section 1115 demonstration.

37. Managed Care Data Requirements. The DVHA must maintain an information system that collects, analyzes, integrates, and reports data. The system must provide information that would be required from managed care entities as set forth in federal regulations at 42 CFR section 438, on program elements including, but not limited to, service utilization, grievances, appeals, and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by the AHS, and on services as set forth under the intergovernmental agreement. DVHA must collect, retain and report encounter data in accordance with the demonstration terms and conditions. All collected data must be available to AHS, and to CMS, upon request.

38. Quarterly Calls. CMS will schedule at least quarterly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, DVHA operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, DVHA financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS will update the state on any amendments or concept papers under review, as well as

federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the project officer and the regional office) will jointly develop the agenda for the calls.

39. Quarterly Reports. The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues;

c. Action plans for addressing any policy and administrative issues identified;

d. A separate discussion of the state efforts related to the collection and verification of claims and encounter data;

e. Evaluation activities and interim findings and a description of state progress towards demonstration goals;

f. Updates on any intended changes in the nominal cost-sharing as stated in the Medicaid state plan, if applicable;

g. The state must report demonstration program enrollment on a quarterly basis using the quarterly report format in Attachment A; and

h. Updates on the Marketplace subsidy program.

Quarterly report for the quarter ending September 30 is due **November 30**
Quarterly report for the quarter ending December 31 is due **February 28**
Quarterly report for the quarter ending March 31 is due **May 31**
Quarterly report for the quarter ending June 30 is due **August 31**

40. Annual Report. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must submit the draft annual report no later than April 1 after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted and posted to the internet.

IX. GENERAL FINANCIAL REQUIREMENTS

41. Aggregate Budget Neutrality Limit. As defined in STCs 51 and 53, Federal funding will be limited to an aggregate amount of $13,209,265,211 over the 11.25 year term of this demonstration for populations receiving benefits through the demonstration (other than medical expenses for the new adult population designated as population 3) and for designated state

health program expenditures under the aggregate budget neutrality agreement. In any year in which the state exceeds the annual target amount set forth in section X "Monitoring Budget Neutrality" below, the state will develop a plan to ensure that the budget neutrality limit is not exceeded, pursuant to the process set forth in section X "Monitoring Budget Neutrality".

42. Per Member Per Month Limit: In addition to the aggregate budget neutrality limit described in STC 51 and 53, total federal funding for medical assistance will be limited over the life of the demonstration extension to an aggregate spending limit based on the actuarially-determined, per member per month limits. Total allowable demonstration expenditures will be reconciled against the aggregate budget neutrality limit and the sum of the annual limits for the extension period (per member per month limits multiplied by actual caseload). The fixed per member per month amount, established in accordance with the requirements set forth under STC 15 and 26, shall be determined no more frequently than annually unless approved by CMS, and must be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The fixed per member per month amount may vary based upon rate cells that take into account different categories of individuals and benefits. The designated state health programs described in STCs 31 and 32 are not included in the per member per month amounts.

43. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using the form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X (Monitoring Budget Neutrality).

44. Reporting Expenditures Subject to the Budget Neutrality Cap. In order to track expenditures under this demonstration, Vermont must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System, following routines from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which the expenditure was made*)*. Reporting for expenditures made subsequent to termination of the demonstration must indicate the demonstration year in which services were rendered. Payment adjustments attributable to expenditures under the demonstration must be recorded on the applicable Global Commitment prior quarter waiver form, identified as either CMS-64.9P Waiver (Medical Assistance Payments) or CMS-64.10P Waiver (Administrative Payments). When populated, these forms read into the CMS-64 Summary sheet, Line 7 for increasing adjustments and Line 10B for decreasing adjustments. Adjustments not attributable to this demonstration should be reported on non-waiver forms, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined in subparagraph (b) below.

a. For each demonstration year, separate form CMS-64.9 waiver and/or 64.9P waiver reports must be submitted reporting expenditures subject to the budget neutrality cap. All

expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures from the separate reports will represent the expenditures subject to the budget neutrality cap (as defined in subparagraph (b) below) Medical expenditures for the new adult group, as described below, are not subject to the demonstration's aggregate cap, but they are subject to Supplemental Budget Neutrality Test 1, as defined in STC 55. As needed and subject to CMS approval, the state will develop reasonable methods to allocate allowable demonstration expenditures (e.g. allocation of administrative costs and managed care investments based on quarterly distribution of medical claims) across demonstration population reporting groups. The Vermont Global Medicaid eligibility groups, for reporting purposes, include the names and definitions described in the table below.

<table>
<tr><th>Corresponding Demonstration population number per STC 17</th><th>Reporting name description</th><th>CMS 64 Reporting Name Effective Through December 31, 2013</th><th>CMS 64 Reporting Name Effective January 1, 2014</th></tr>
<tr><td rowspan="3">Demonstration Populations 1-2</td><td>Report expenditures for individuals eligible as aged, blind, or disabled under the state plan</td><td><u>"ABD"</u></td><td><u>"ABD"</u></td></tr>
<tr><td>Report the expenditures for all non-ABD children and adults in the State plan mandatory and optional categories, with the exception of adults eligible under demonstration population 3</td><td><u>"ANFC"</u></td><td rowspan="2"><u>"non-ABD"</u></td></tr>
<tr><td>Report for all expenditures for all non-ABD children and adults in optional categories</td><td><u>"Optional Expansions"</u></td></tr>
<tr><td rowspan="2">Demonstration Population 3</td><td>Report for all medical expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119</td><td>Not Applicable</td><td><u>"New Adult Group Medical"</u></td></tr>
<tr><td>Report for any MCO investments or other administrative expenses made for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.</td><td>Not Applicable</td><td><u>"New Adult Group MCO investments"</u></td></tr>
<tr><td>Demonstration Population 4</td><td rowspan="4">Effective through December 31, 2013: Report for all expenditures for individuals eligible as non-categorical health care expansions through VT global

Effective January 1, 2014, the expenditure authority for demonstration populations 5, 6, 10, and 11 expires</td><td rowspan="4"><u>"VT Global Expansion"</u></td><td><u>"VT Global Expansion"</u></td></tr>
<tr><td>Demonstration Population 5</td><td rowspan="3">Not applicable for demonstration populations 5, 6, 10, and 11.</td></tr>
<tr><td>Demonstration Population 6</td></tr>
<tr><td>Demonstration Population 10</td></tr>
</table>

Corresponding Demonstration population number per STC 17	Reporting name description	CMS 64 Reporting Name Effective Through December 31, 2013	CMS 64 Reporting Name Effective January 1, 2014
Demonstration Population 11			
Demonstration population 7 Demonstration Population 8	Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx) The expenditure authority for non-Medicare individuals in this population expires December 31, 2013.	**"VT Global Rx"**	**"VT Global Rx"**
Designated State Health Programs (Note: As described in STCs 31 and 32, these expenditures are not demonstration populations but are eligible for Federal Financial Participation and are counted against the demonstration's aggregate budget neutrality cap)	Report for designated state health program expenditures for the state-funded Marketplace subsidy program for individuals at or below 300 percent of the FPL who purchase health care coverage in the Marketplace.	Not Applicable	**"Marketplace Subsidy"**
	Report for designated state health program expenditures for individuals receiving CRT services who are not Medicaid enrolled		**"CRT DSHP"**

It is understood that individuals receiving Community Rehabilitation and Treatment (CRT) Services are included in MEGs that are reported on the CMS-64. Reporting to CMS will occur via a supplemental information report provided as backup to the CMS-64. This report will be submitted concurrently with the other CMS-64 backup documentation submitted every quarter.

b. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of the individuals who are enrolled in this demonstration (as described in subparagraph (a) of this section) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on line 49 of forms CMS-64.9 waiver and/or 64.9P waiver.

c. Premiums and other applicable cost-sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS on the CMS-64 Summary Sheet, Line 9D "Other." In order to ensure that the demonstration is properly credited with premium collections, please indicate in the CMS-64 Certification "Footnotes" section that Line 9D of the Summary Sheet is for Global Commitment Collections only.

d. Administrative costs must be included in the budget neutrality limit. Vermont will not be

at risk for expenditures related to systems enhancements, including any new procurements related to claims processing, program management, and eligibility. To the extent that that state is eligible for enhanced FMAP for special initiatives recognized by CMS pursuant to subparagraph (h) below, the state will separately identify and report these expenses in a format agreed upon with CMS. All administrative costs not included in the expenditures reported on line 49 of forms CMS-64.9 waiver and/or 64.9 waiver (described in 40.b of this section) must be identified on the forms CMS-64.10 waiver and/or 64.10P waiver.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all title XIX claims for services during the demonstration period (including any cost settlements and claims incurred during the demonstration but paid subsequent to the end date of the demonstration) are considered allowable expenditures under the demonstration and must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

f. At the end of the demonstration, all MCO investment and administrative claims for expenditures subject to the budget neutrality cap (including any cost settlements and non-title XIX claims incurred during the demonstration but paid subsequent to the end date of the demonstration) must be made within 2 quarters (6 months) after the calendar quarter in which the state made the expenditures. During the latter 6 month period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g. Disproportionate Share Hospital (DSH) payments are not counted as expenditures under the demonstration.

h. The demonstration does not prohibit the state from requesting to implement special initiatives available, and taking advantage of enhanced Federal Medical Assistance Percentage (FMAP) for these initiatives, under ACA subject to the federal approval process established for these initiatives.

45. Reporting Member Months. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals, who are eligible for 2 months, each contributes 2 eligible member months to the total, for a total of 4 eligible member/months

46. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37 based on the PMPM limit (or a percentage of the PMPM limit) and

projected caseload for the quarter. In addition, the estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the form CMS-37.12 for both the medical assistance program and administrative costs outside of the PMPM limit. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended. Intergovernmental transfers of the individual per member per month fixed amount from AHS to DVHA are not reportable expenditures, but provide funding for reportable DVHA expenditures. CMS will reconcile expenditures reported on the form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

47. Sources of Non-Federal Share. The state certifies that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS will review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

48. State Certification of Public Expenditures. Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also

provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers as a source of non-federal share to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment. Intergovernmental transfers are not themselves expenditures, but may be a source of funding for expenditures.

49. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

50. MSIS Data Submission. The state must submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The state must ensure, within 120 days of the approval of the demonstration, that all prior reports are accurate and timely.

X. MONITORING BUDGET NEUTRALITY

51. Aggregate Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration, which is comprised of an aggregate limit plus a supplemental test for new adult group medical expenditures. All other expenditures under the demonstration (including non-medical expenses for the new adult group and expenditures for designated state health programs) are subject to the aggregate limit. The aggregate budget neutrality limit over the life of the demonstration is defined in STC 53. The Supplemental Test 1 is described in STC 55. Any excess spending from Supplemental Test 1 is counted towards the aggregate cap. The per member per month budget neutrality expenditure limits are set on a yearly basis with a cumulative per member per month expenditure limit for the length of the entire demonstration extension.

52. Risk. The state shall be at risk for the both the number of enrollees in the demonstration as well as the per capita cost for demonstration eligibles under the aggregate budget neutrality agreement as defined in STCs 51 and 53. The cumulative, per member per month limit will vary based on actual caseload.

The state shall not be at risk for the number of enrollees in the new adult group, as described in Supplemental Test 1 in STC 55.

53. Budget Neutrality Aggregate Cap. Budget neutrality is determined on an aggregate cap basis as shown below:

DY/ FFY	Annual Budget Neutrality Cap (total computable)
DY 1/ FFY 2006	$ 841,266,663
DY 2/ FFY 2007	$ 843,594,654
DY 3/ FFY 2008	$ 919,247,991
DY 4/ FFY 2009	$ 1,002,321,263
DY 5/ FFY 2010	$ 1,093,591,603
Subtotal Initial Approval Period (DY 1 to DY 5)	***$ 4,700,022,174***
DY 6/ FFY 2011	$ 1,165,191,563
DY 7/ FFY 2012	$ 1,248,077,166
DY 8/ FFY 2013	$ 1,337,393,583
Subtotal First Extension Period (DY 6 to 8)	***$ 3,750,662,312***
DY 9a/ 10/01/2013 – 12/31/2013	$ 505,202,312
DY 9b/ CY 2014	$ 1,334,452,085
DY 10/ CY 2015	$ 1,416,117,210
DY 11/ CY 2016	$ 1,502,809,118
Subtotal for Second Extension Period (DY 9 to 11)	***$ 4,758,580,725***
Cumulative Total (Initial Approval Plus Extension Periods)	**$13,209,265,211**

54. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

55. Supplemental Budget Neutrality Test 1: New Adult Group. Effective January 1, 2014, adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. However, medical expenses related to the new adult group are not added to the demonstration's aggregate cap. Therefore, a separate expenditure cap is established for medical expenditures for this group, to be known as Supplemental Budget Neutrality Test 1.

a. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 1.

MEG	TREND	DY 9 – PMPM	DY 10 – PMPM	DY 11 – PMPM
New Adult Group Medical	4.7%	$453.72	$475.04	$497.37

b. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to subparagraph (a) for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

c. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The Federal share of the Supplemental Cap 1 is obtained by multiplying total computable Supplemental Cap 1 by the Composite Federal Share 1, defined in subparagraph (d) below.

d. Supplemental Budget Neutrality Test 1 is a comparison between the Federal share of the Supplemental Cap 1 and total FFP reported by the state for the new adult group.

e. If total FFP for the new adult group should exceed the Federal share of Supplemental Cap 1 after any adjustments made to the budget neutrality limit as described in subparagraph (b), the difference must be reported as a cost against the aggregate budget neutrality cap described in STC 53.

f. Savings generated from the medical expenses related to the new adult group may not be used for MCO investments, designated state health programs, or any other expenditures under the aggregate budget neutrality cap.

   As described in STC 44(a), all expenses related to administrative expenses and MCO investments for the new adult group are reported as a cost against the aggregate budget neutrality cap and are paid for by savings derived from elsewhere in the demonstration.

g. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There is 1 Composite Federal Share Ratio for this demonstration: Composite Federal Share 1, based on the expenditures for the new adult group under this STC. Should the demonstration be terminated prior to the end of

the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

56. How the Limits will be Applied. The limits calculated in STC 53 will apply to actual expenditures for the demonstration including claims incurred during the demonstration period but paid after the end of the demonstration, as reported by the state under section IX "Evaluation of the Demonstration". If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess federal funds will be returned to CMS. There will be no new limit placed on the FFP that the state can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the eleven and a quarter-year period, the budget neutrality test will be pro-rated based on the time period through the termination date.

57. Enforcement of Budget Neutrality. CMS will enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

58. Expenditure Review and Cumulative Target Calculation. CMS will enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the state under budget neutrality. Using the schedule below as a guide, if the state exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative Target (Total Computable Cost)	Cumulative Target Definition	Percentage
Year 9b	$10,290,338,883	Year 9b budget estimate plus	3 percent
Year 10	$11,706,456,093	Years 9b and 10 combined budget estimate plus	1.5 percent
Year 11	$13,209,265,211	Years 9b through 11 combined budget estimate plus	0 percent

XI. EVALUATION OF THE DEMONSTRATION

59. Submission of Draft Evaluation Design. The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS' approval of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II "Program Description and Objectives", as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of demonstration funds. The evaluation design must also discuss the state's plans to evaluate the Marketplace subsidy program. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

60. Interim Evaluation of Marketplace Subsidy Program. The state must submit an interim evaluation of the Marketplace subsidy program to CMS by September 1, 2014 that meets the requirements specified in the CMS-approved evaluation design.

61. Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

62. Final Evaluation Design and Implementation. CMS must provide comments on the draft evaluation design described in STC 59 within 60 days of receipt, and the state must submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after the expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

63. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the demonstration the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS as requested.

XII. USE OF DEMONSTRATION FUNDS

64. Use of Demonstration Funds. Expenditures within the per member per month limit (calculated over the life of the demonstration) can include expenditures for the following purposes:

a. Reduce the rate of uninsured and/or underinsured in Vermont;

b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

XIII. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
120 days after approval	Submit Draft Evaluation Plan	Section XI, STC 59
September 1, 2014	Interim Evaluation of Marketplace Subsidy Program	Section XII, STC 58
April 30, 2017	Submit Final Evaluation Plan	Section XI, STC 62

Recurring Date	Deliverable	STC Reference
Not later than April 1st	Draft Annual Report	Section VIII, STC 40
	Interagency Agreement	Section VI, STC 25
	PMPM limit calculation	Section VI, STC 25
Quarterly		
	Quarterly Operational Reports	Section VIII, STC 39
	CMS-64 Reports	Section IX, STC 43

ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

Under section VIII, STC 39, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Vermont Global Commitment to Health

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (10/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2010 (10/01/2010 – 12/31/2010)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Enrollment Counts Note: Enrollment counts should be person counts, not member months.

Demonstration Populations	Current Enrollees: last day of the quarter: xx/xx/xxxx	Previously reported enrollees last day of quarter: xx/xx/xxxx	Variance
Demonstration Population 1:			
Demonstration Population 2:			
Demonstration Population 3:			
Demonstration Population 4:			
Demonstration Population 5:			
Demonstration Population 6:			
Etc…			

Outreach/Innovative Activities
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Expenditure Containment Initiatives
Identify all current activities, by program and or Demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Demonstration Population 1:				
Demonstration Population 2:				
Demonstration Population 3:				
Demonstration Population 4:				
Demonstration Population 5:				
Demonstration Population 6:				
Demonstration Population 7:				
Demonstration Population 8:				
Demonstration Population 9:				
Demonstration Population 10:				
Demonstration Population 11:				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

Attachment B. Summary of Catamount Health

Catamount Health is a new fully insured product that will be available through private insurers in Vermont. The Catamount Health Assistance Program offers a subsidized insurance program to Vermont residents who have been without health insurance coverage for a year or more, have income at or below 300 percent of FPL, and who do not have access to employer-sponsored insurance that has been approved and is cost effective. The beneficiary's share of the premium is based on income.

Participating Carriers
Insurers currently offering products in the small group market may offer Catamount Health. The benefits to be provided in the plan are set out in the legislation creating the program. Insurers offering Catamount Health are required to provide benefit plans that are actuarially equivalent to the following, which are modeled on a PPO plan:

- A $500.00 annual deductible for an individual and a $1000.00 deductible for a family for health services received in network;

- A $1000.00 annual deductible for an individual and a $2,000.00 deductible for a family for health services received out of network;

- 20 percent co-insurance, in and out of network;

- $10.00 office co-payment;

- Prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for non-preferred drugs;

- Out-of-pocket maximums of $1,050.00 for an individual and $2,100.00 for a family for in-network services and $2,100.00 for an individual and $4,000.00 for a family for out- of-network services; and

- A waiver of the deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.

ATTACHMENT C: Premiums and Co-Payments for Demonstration Expansion Populations

Population	Premiums	Co-Payments	State Program Name
Vermont Health Access Plan (VHAP) Expansion Populations			
Demonstration Population 4: Underinsured children with income between 225 percent and up to and including 300% of the FPL who are not otherwise eligible for Medicaid or the Children's Health Insurance Program	Premiums not to exceed the following: 186-225% FPL: $15/month/family 226-300% FPL: $20/month/family	Not to exceed the nominal co-payments specified in the Medicaid State plan	Dr. Dynasaur
Demonstration Population 5: Adults with children with income between 150 percent and up to and including 185 percent of FPL	Premiums not to exceed the following: 150-185% FPL: $49/month	Not to exceed the nominal co-payments specified in the Medicaid State Plan plus $25 per emergency room visit, with no charge if admitted to the hospital	VHAP
Demonstration Population 6: Adults with income up to and including 150 percent of FPL	Premiums not to exceed the following: 50-75% FPL: $7/month 76-100% FPL: $25/month 101-150% FPL: $33/month	Not to exceed the nominal co-payments specified in the Medicaid State Plan plus $25 per emergency room visit, with no charge if admitted to the hospital	VHAP
Demonstration Population 7: Effective through December 31, 2013: Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible for full benefits. Effective January 1, 2014: Medicare beneficiaries with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Premiums not to exceed the following: 0-150% FPL: $15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan	VHAP Pharmacy/ VPharm1
Demonstration Population 8: Effective through December 31, 2013: Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, not otherwise categorically eligible. Effective January 1, 2014: Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP), but are not otherwise categorically eligible.	Premiums not to exceed the following: 151-175% FPL: $20/month/person 176-225% FPL: $50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan	VScript/VPharm2 or VScript Expanded/ VPharm3
Demonstration Population 9: Individuals with persistent mental illness with income up to and including 150 percent of FPL	Premiums not to exceed the amounts indicated in the Medicaid State Plan	Not to exceed the nominal co-payments specified in the Medicaid State plan	VHAP
Premium Assistance Expansion Populations			
Demonstration Population 10: ESI Premium Assistance Expansion Population	Premiums not to exceed the following: 50-75% FPL: $7/month 76-100% FPL: $25/month 101-150% FPL: $33/month 150-185% FPL: $49/month	Not to exceed the nominal co-payments specified in the Medicaid State Plan plus $25 per emergency room visit, with no charge if admitted to the hospital	VHAP-ESI
Demonstration Population 11: Catamount Health Premium Assistance Expansion Population	Based on lowest cost plan; premium amounts will be the same as Catamount Based on lowest cost plan; amounts dictated by Vermont Legislation	N/A	Non-VHAP ESI or Catamount